AA. Coordination and Continuation of Care

The MCO must ensure that the care of new enrollees is not disrupted or interrupted. The MCO must ensure continuity of care for new enrollees receiving health care under Medicaid fee-for-service prior to their enrollment in the MCO. The MCO must:

1. Authorize coverage of services with the enrollee's current providers for the first 60 days of enrollment or until the first of the month following completion of the initial assessment and care plan, whichever is later. After the first 60 days, the enrollee may choose disenrollment or may change to a different MCO if s/he is not satisfied with providers offered by the MCO. The Enrollment Specialist will obtain provider information from new enrollees whenever possible and share that information with the assigned MCO. Exceptions will be allowed in situations where the MCO can document a history of quality concerns with the provider.

2. The MCO will honor fee-for-service authorizations for therapies and personal care at the level authorized by fee-for-service for 60 days or until the first of the month following completion of the initial assessment and care plan, whichever is later. Exceptions will be allowed in situations where the enrollee agrees to change providers, the enrollee agrees to a lower level of care, or if the MCO can document that continuing the care would result in abuse, safety or quality concerns. This does not extend authorizations beyond the time or visits approved under fee-for service.

3. The MCO will allow continuation of medications already in use by the enrollee subject to a physician's prescription order. The MCO may consult with the enrollee's physician to determine if transition to a generic medication or therapeutic equivalent will meet the enrollee's needs. The MCO will not deny coverage of a medication already in use unless the prescriber agrees and orders a substitute drug.

In addition, the MCO must have systems in place to ensure well-managed patient care, including at a minimum:

4. Managing and integrating health care through a primary provider, gatekeeper, or other means.

5. Systems to ensure referrals for medically necessary, specialty, secondary and tertiary care.

6. Systems to ensure provision of care in emergency situations, including an education process to help assure that recipients know where and how to obtain medically necessary care in emergency situations.

7. Systems that clearly specify referral requirements to providers and subcontractors. The MCO must keep copies of referrals (approved and denied) in a central file or the patient's medical records.

8. Systems to ensure the provision of a clinical determination, of the medical necessity and appropriateness of the consumer to continue with mental health or substance abuse providers who are not subcontracted by the MCO. The determination must be made within 10 business days of the consumer's request. If the MCO determines that the consumer does not need to continue with the non-contracted provider, it must ensure an orderly transition of care.

9. Have a system in place that utilizes the opportunities that exist for the SSI-Medicaid recipients through the Public Schools.

10. MCO must have a detailed automated system for collecting all information on consumer contacts by care coordinators, case managers, and any other staff that has a direct impact on the consumer's access to services.

11. MCO shall assist members who wish to receive care through another SSI MCO or return to the FFS system by making appropriate referrals and by assisting in the transfer of medical records to new providers.